

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

01822

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALICE J. ALFREE			2a. DATE OF DEATH MONTH DAY YEAR Jan 25, 1985			2b. HOUR 6A M			
3 SEX Female		4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR Feb 2, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Laundry	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Delaware		13b. COUNTY N.C.		13c. CITY OR TOWN Blackbird		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Townsend-R.D. 1994	
14. FATHER'S NAME FIRST MIDDLE LAST Emmie - Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma - Tucker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-22-8500		17. INFORMANT ADDRESS Roy Alfree, Sr - Blackbird, Del.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute renal failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) hypertension 20 yrs approx.			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **3/14**, 19**84**, to **1/24**, 19**85**, that (I) (we) last saw the deceased alive on **1/24**, 19**85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Kenneth Lewis MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH LEWIS MD				22e. ADDRESS 12 Pennington St Middletown, Del.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 28, 1985		23c. NAME OF CEMETERY OR CREMATORY Townsend Cem.		23d. LOCATION (CITY OR TOWN) Townsend-N.C. STATE Del.	
24. FUNERAL DIRECTOR Robert C. Guterson - Middletown, Del.				25a. DATE REC'D. BY REGISTRAR JAN 31 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 01823

FOR
STATE
REGISTRAR

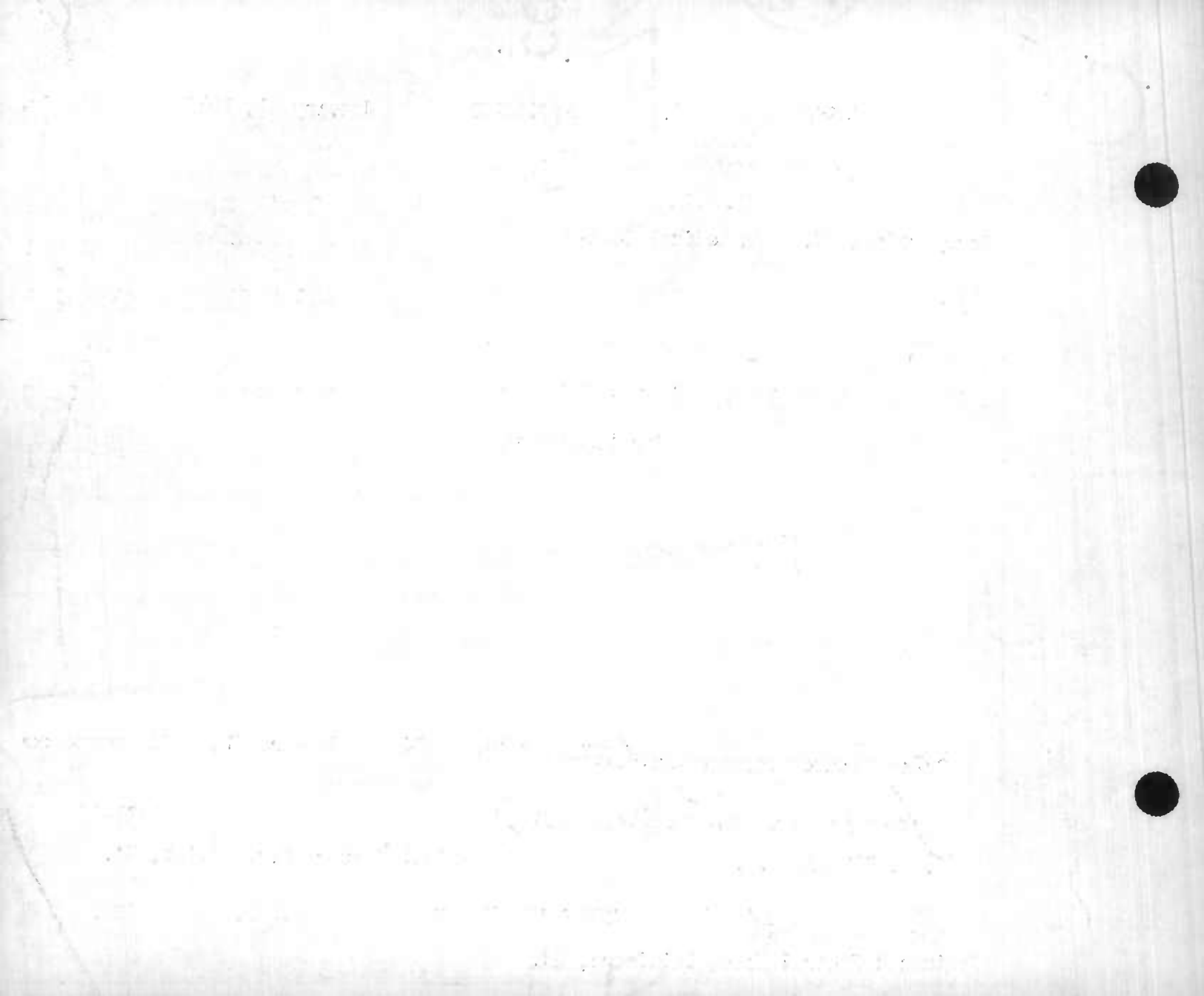
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH A. ANNECHINO			2a. DATE OF DEATH MONTH DAY YEAR January 21, 1985		2b. HOUR 12:05pm								
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 19 1928		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.							
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE		12b. KIND OF BUSINESS OR INDUSTRY STEVENS CO.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.						13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4800 PARKSIDE DRIVE 21206	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH ANNECHINO						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE D'ORAZIO							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1946-1947		17. INFORMANT ADDRESS CARMEN ANNECHINO (BROTHER) ADDRESS SAME							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) (this hospital) attended the deceased from November 16, 1984, to January 21, 1985. I saw the body after death and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Joaquin R. Garcia						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-21-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. R. GARCIA, M.D.						22e. ADDRESS VA Medical Center, Perry Point, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/24/85		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.					
24. FUNERAL DIRECTOR'S NAME Schimineuk Funeral Home, Baltimore, Md.						25a. DATE REC'D. BY REGISTRAR JAN 23 1985		25b. REGISTRAR'S SIGNATURE Lisa Davidson-Randall					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR
1- STATE 5/17/85 rja
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2a. DATE KNOWN OF DEATH ☒ MONTH ☐ DAY ☐ YEAR ☐ HOUR
1 9 851. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Beverly Anne Archer

3. SEX female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR Mar. 12, 1940 6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS. 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 9 1985 2d. HOUR 11:49 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.

10. CITY OR TOWN OF DEATH Perryville 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U.S. Route 40, Perry Point

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker 12b. KIND OF BUSINESS OR INDUSTRY US Army

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Aberdeen

13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 453 W. Bel Air Ave./21001

14. FATHER'S NAME FIRST MIDDLE LAST Vilna Ollyce Holmes

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Anne Kimberlin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. 72-74 442-40-9258

17. INFORMANT ADDRESS MD, 21001 Vicki King, 453 W. Bel Air Ave., Aberdeen.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) Bronchial asthma
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY) M.D. Deputy

MEDICAL EXAMINER

DATE SIGNED 1-10-85

EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vital

ADDRESS Union Hospital, Elkton, MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Cremation

23b. DATE Jan. 10, 1985

23c. NAME OF CEMETERY OR CREMATORY Cratin and Ferris

23d. LOCATION CITY OR TOWN COUNTY STATE West Chester, Chester, Penna.

24. FUNERAL DIRECTOR

NAME Tarring Funeral Home, Aberdeen, Md. 21001-3399

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JAN 14 1985 Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. 2. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PR OR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nina R. Ashton			2a. DATE OF DEATH MONTH DAY YEAR Jan. 10, 1985		2b. HOUR 9:05A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-05-86	6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10. CITY OR TOWN OF DEATH Rising Sun	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Pa.			13b. CITY OR TOWN Chester	13c. CITY OR TOWN Lincoln Univ.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Hadley Reeve			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adeline Coppock		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-74-3093	17. INFORMANT ADDRESS: Catherine Graybeal, R.D.#1, Box 97		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.Congestive heart failure
Advanced arteriosclerosisAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 days

5 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 1-9, 1985, to Jan 1-9, 1985, that (I) (we) lost
saw the deceased alive on Jan 1-9, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE REG. D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Richard L. Gooker Rising Sun, Md.

JAN 16 1985

John Davidson



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Anthony A Asti</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1/10/85</i>		2b. HOUR <i>0925</i> M
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 24, 1895</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Italy</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i> MD	
10. CITY OR TOWN OF DEATH <i>ELKTON</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Bakery Sales</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Bakery</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Delaware</i>			13b. COUNTY <i>New Castle</i>	13c. CITY OR TOWN <i>Newark</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Guerino Asti</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Angelina Micheli</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>16-910-9350</i>		17. INFORMANT ADDRESS <i>Fran Asti 9 Hillwood Rd. Glen Farms</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Cardiac Arrest*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b)

*Congestive Heart Failure**Few years*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Pneumonia

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1, 1984</i> to <i>1.10.1985</i> , that (I) (we) lost saw the deceased alive on <i>1.10.1985</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Sheelmoan S. Saahdev</i>	DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>1.10.85.</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SHEELMOHAN S. SAHDEV</i>		22e. ADDRESS <i>204 Bow St, ELKTON Md 21921</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>JAN. 11/1985</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CRATIN + FERRIS</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Westchester Del. PA.</i>
24. FUNERAL DIRECTOR NAME <i>Gee Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 1. 6 1985</i>	
ADDRESS <i>ELKTON, MD.</i>		SIGNATURE <i>Gee Funeral Home</i>	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

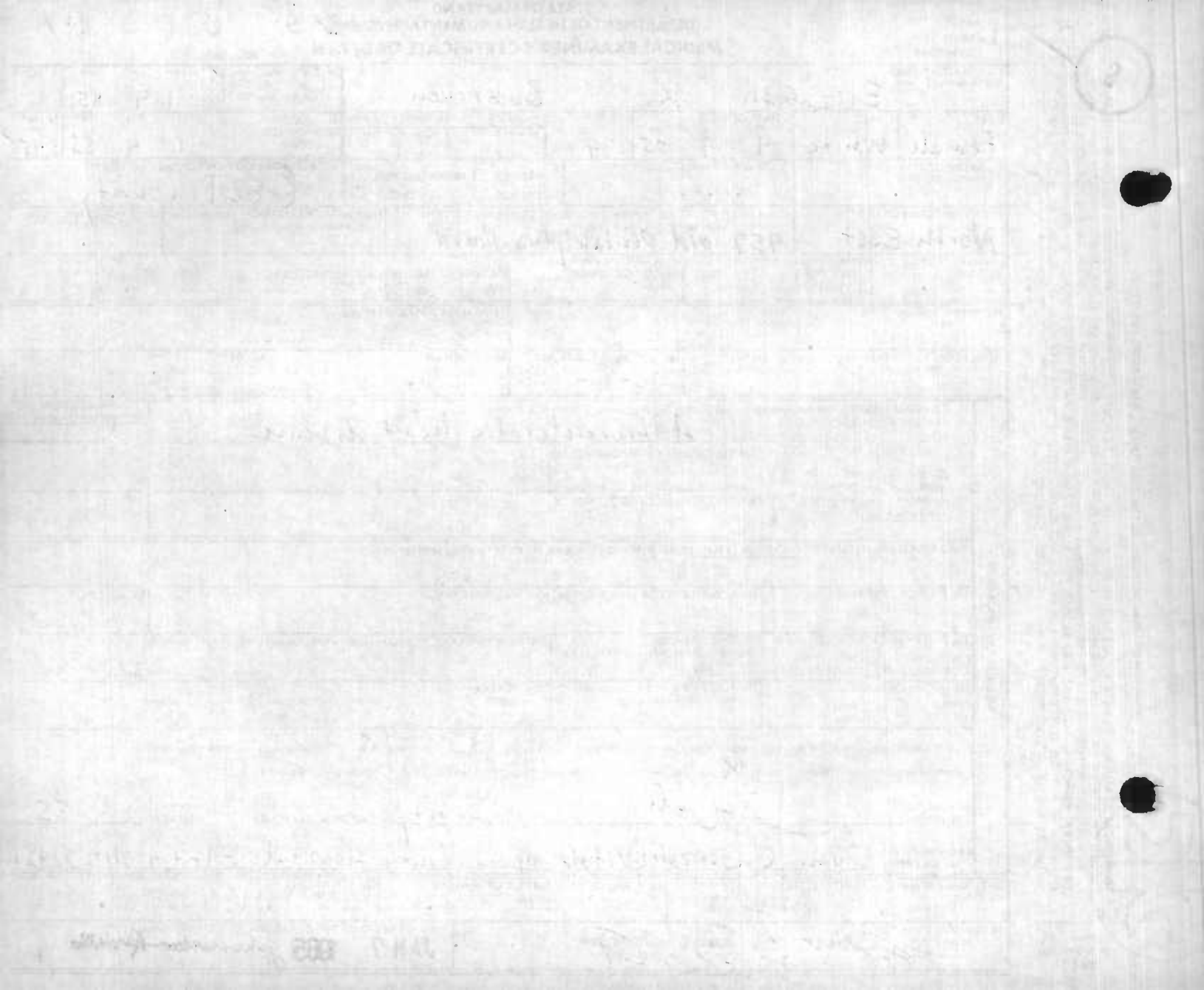
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
Elizabeth Kibler Bakeoven								14 1985								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	White	4 7 05		79		YRS.		MONTHS		1 4 1985						2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		<input type="checkbox"/> NEVER MARRIED		<input type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH				MD	
Va.		U.S.A.										Cecil County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
North East		957 Old Philadelphia Road		Nurse Aid		Govt.											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Cecil		North East		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		957 Old Phila Rd.									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST					
Claud D. Kibler						Mary Ella Burner											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		213-20-1628		John S. Dean		51 Deans La. North East, Md. 21901											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Atherosclerotic heart disease		DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
				(b)				DUE TO, OR AS A CONSEQUENCE OF									
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Juan C Gonzalez-Vital MD		Deputy		1-4-85													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Juan C Gonzalez-Vital MD		Union Hospital Elkton, MD 21921															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		1-7-85		North East Meth.		North East Cecil Md.											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Crouch Funeral Home North East, MD		JAN 7 1985		John Davidson-Randall													

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal case must be notified at once.DHMH-16 20M
(VRA 15, 4) 7/78STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

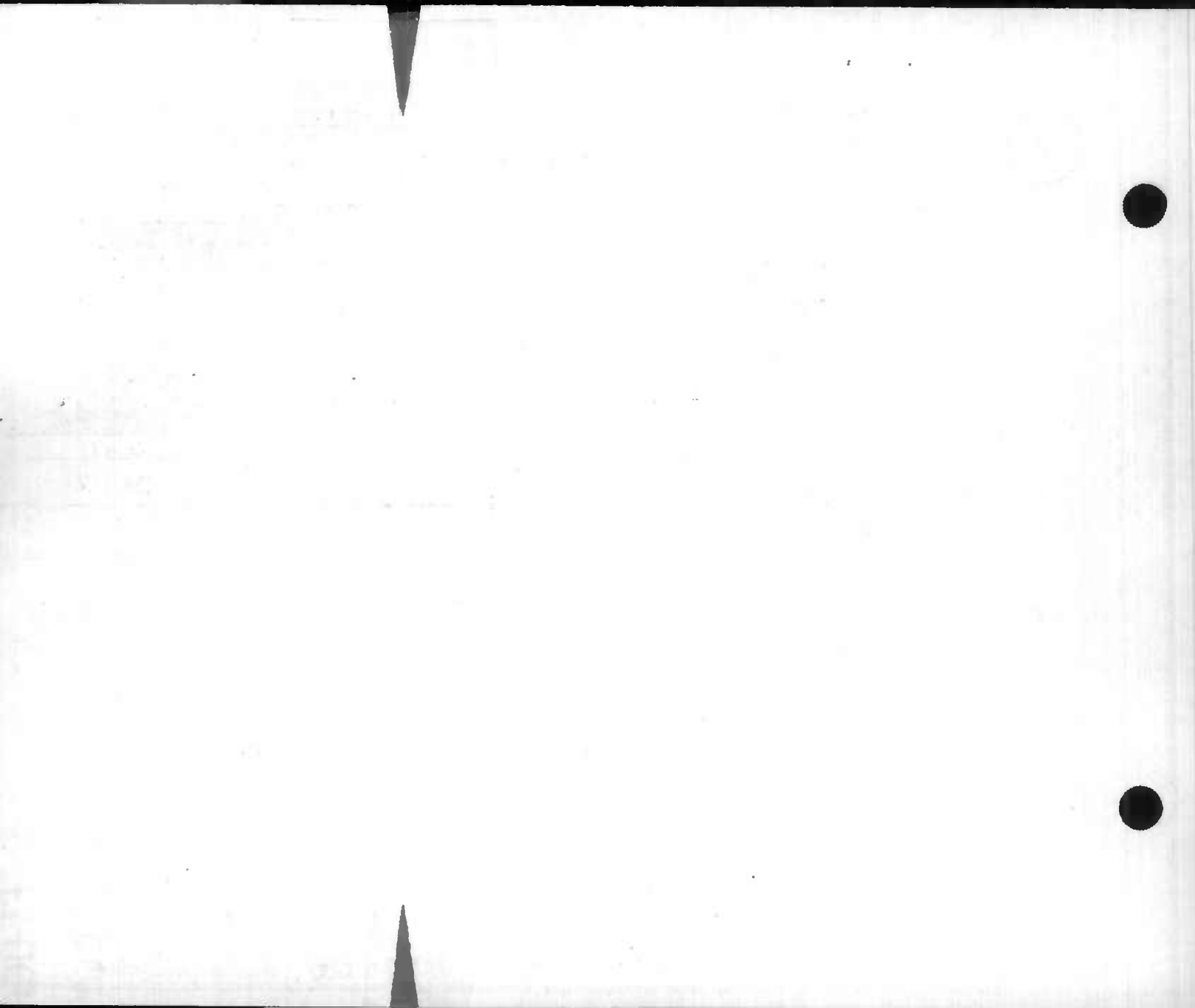
JAN 8 5 0 1 8 2 8

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mark D. Brown			2a. DATE OF DEATH MONTH DAY YEAR January 18 1985		2b. HOUR 10:20am
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 20 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 yrs.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Perryville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 97 Browns Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) P.M. & R.		12b. KIND OF BUSINESS OR INDUSTRY V.A.M.C.,
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Cecil 13c. CITY OR TOWN Perryville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 97 Browns Road 21903	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dulcinea --- Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 406-09-9146	17. INFORMANT ADDRESS Helen W. Brown 97 Brown Rd., P.O. Box 59 Perryville, Maryland 21903			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHITIS</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 yr. 20 yr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>SEVERE DEPRESSION</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK NOT AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>NOV. 14</u> , 19 <u>84</u> , to <u>JAN 18</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>JAN 9</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Andrew P. Fridberg MD</u>		DEGREE <u>MD</u>		22c. DATE SIGNED 1-19-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew P. Fridberg, M.D.		22e. ADDRESS 502 Lewis St., Havre de Grace, Md. 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 21, 1985	23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Havre de Grace Harford Md.	
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son</u>		25. DATE REC'D. BY REGISTRAR JAN 25 1985			
24b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodella</u>		25b. REGISTRAR'S SIGNATURE			

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 2 9

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen T. Carter			2a. DATE OF DEATH MONTH DAY YEAR Jan. 31, 1985			2b. HOUR 7:55 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 16, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Rising Sun		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE PA		13b. COUNTY Chester		13c. CITY OR TOWN Oxford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 227 E. Mt. Vernon St. 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Ralph Tubbs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Watkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 181-03-6902		17. INFORMANT ADDRESS Pa. 19390 Donald Carter, 203 Kelton Rd., West Grove			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b) stroke, small

DUE TO, OR AS A CONSEQUENCE OF

(c) Alzheimer's Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 weeks4 weeksmany years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

inability to swallow, feeding tube

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from		19 <u>56</u> to <u>Jan 31</u> 19 <u>85</u>		that (I) (we) lost			
saw the deceased alive on <u>Jan 31</u> 19 <u>85</u>		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>view the body after death.</u>					
22a. SIGNATURE <u>Faye R. Doyle MD</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Faye R. Doyle, M.D.</u>		22e. ADDRESS <u>133 Locust St. Oxford, Pa.</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>2/2/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Oxford Chester Pa.</u>	
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24. FUNERAL DIRECTOR NAME <u>Richard L. Goodie</u>		ADDRESS <u>Rising Sun, Pa.</u>		25a. DATE REC'D. BY REGISTRAR <u>FEB 8 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Gilda Davidson-Randall</u>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ceremonially filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes on lined paper, including the word "Osteoarthritis" and a date "26 Jan 31".



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8501830

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ESTHER B. COOLEY			2a. DATE OF DEATH MONTH DAY YEAR 1 1 85		2b. HOUR 1120 A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR JUNE 21, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John J. Mueller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha - Frederick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 393-03-9300D		17. INFORMANT ADDRESS Mrs. Hope B. Beach, Elkton, Md. 21921	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min. 31 d.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Diabetes mellitus; cerebral vascular disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/1/84 to 1/1/85 , that (I) (we) last saw the deceased alive on 1/1/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.					
22b. SIGNATURE Edgar E. Folk III		DEGREE M.D.		22c. DATE SIGNED 1/1/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar E. Folk III		22e. ADDRESS Union Hospital, Elkton, Md. 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 4, 1985		23c. NAME OF CEMETERY OR CREMATORY Fassett Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Edgerton, Wisconsin					
24. FUNERAL DIRECTOR Ralph E. Hicks		ADDRESS HICKS HOME FOR FUNERALS, P.A., Elkton, Md. 21921		25a. DATE REC'D. BY REGISTRAR JAN 7 1985	
25b. REGISTRAR'S SIGNATURE Kelia Davidson-Randall					

MEDICAL CERTIFICATION

BP

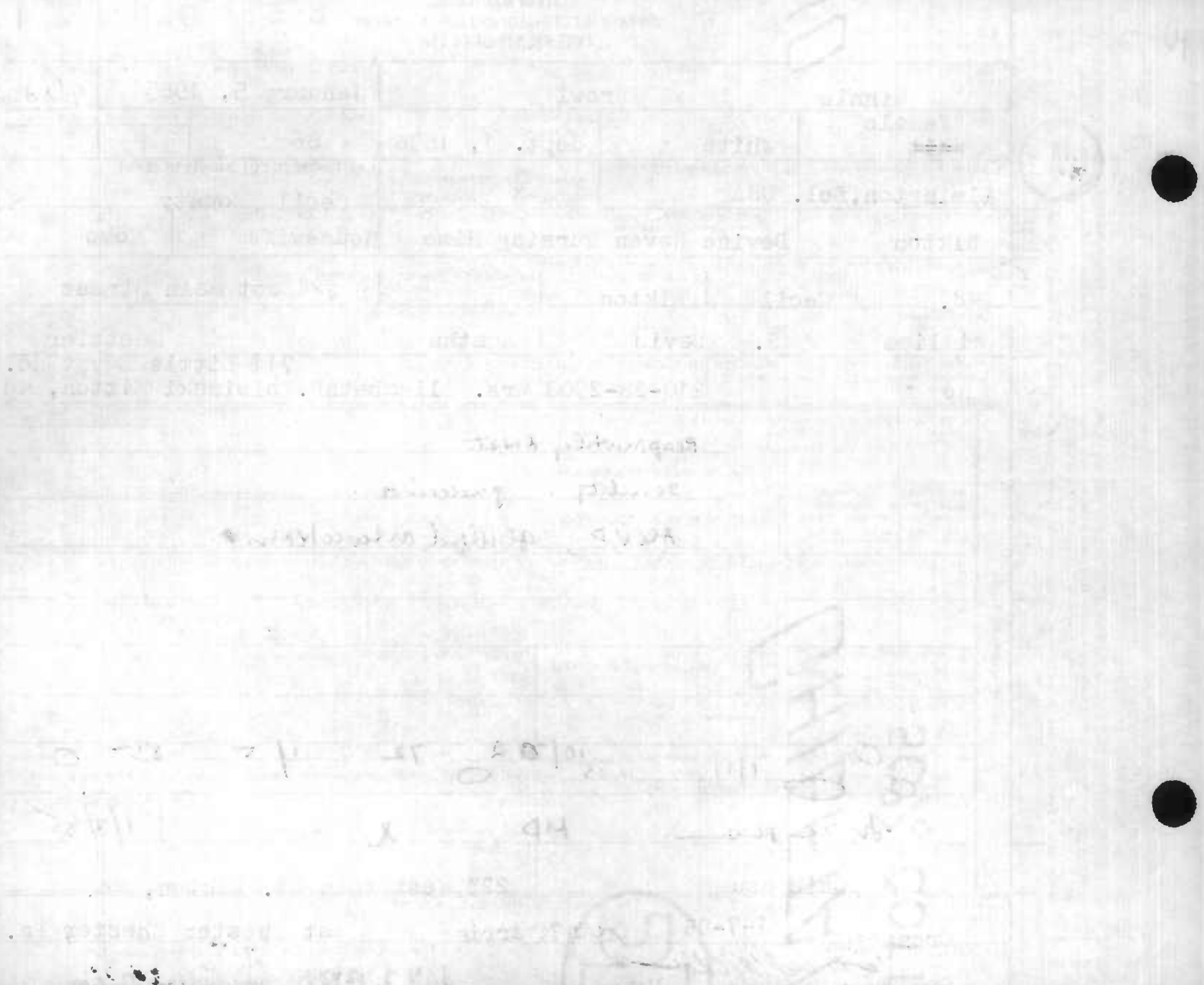
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1000





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 85 01832				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 1-30-85				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BRADFORD WILLIAM DAWKINS					2b. HOUR M				
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 6 11		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD			
10. CITY OR TOWN OF DEATH ELATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. FARMER		12b. KIND OF BUSINESS OR INDUSTRY GRAIN	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY CECIL		13c. CITY OR TOWN ELATON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21921 HDC 1679 AUGUSTINE HERMAN	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS DAWKINS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE MANSFIELD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 222 04838		17. INFORMANT ADDRESS LORANA J. DAWKINS ELATON MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction with shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 28 19 85 to Jan 30 19 85, that (I) (we) lost saw the deceased alive on Jan 29 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE RICHARD S. ACKART						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-1-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD S. ACKART						22e. ADDRESS 221 E. MAIN ST. ELATON MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BUTIAH		23b. DATE 2-2-85		23c. NAME OF CEMETERY OR CREMATORY BETHEA		23d. LOCATION CITY OR TOWN COUNTY STATE CHESAPEAKE CITY MD			
24. FUNERAL DIRECTOR'S NAME Robert Howard						25a. DATE REC'D. BY RETURNEE 2-1-85		25b. SIGNATURE OF RETURNEE John H. Anderson	
24. FUNERAL HOME R.T. FORD FUNERAL HOME CITY MD									

BP _____

[Faint handwritten notes at the bottom of the page]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 3 3

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAEID THOMAS DeManincor			2a. DATE OF DEATH MONTH 11 DAY 13 YEAR 85			2b. HOUR 1915 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH February DAY 14 YEAR 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.			
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tool & Die Maker		12b. KIND OF BUSINESS OR INDUSTRY Corp. Westinghouse	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9 Joseph Gallaher Street, 21921	
14. FATHER'S NAME FIRST Samuel MIDDLE - LAST deManincor				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE - LAST Reisco					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 195-16-6365		17. INFORMANT ADDRESS Mrs. Mary deManincor, Elkton, Md. 21921			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

Pneumonia

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Rt. Hemiplegia

MEDICAL CERTIFICATION

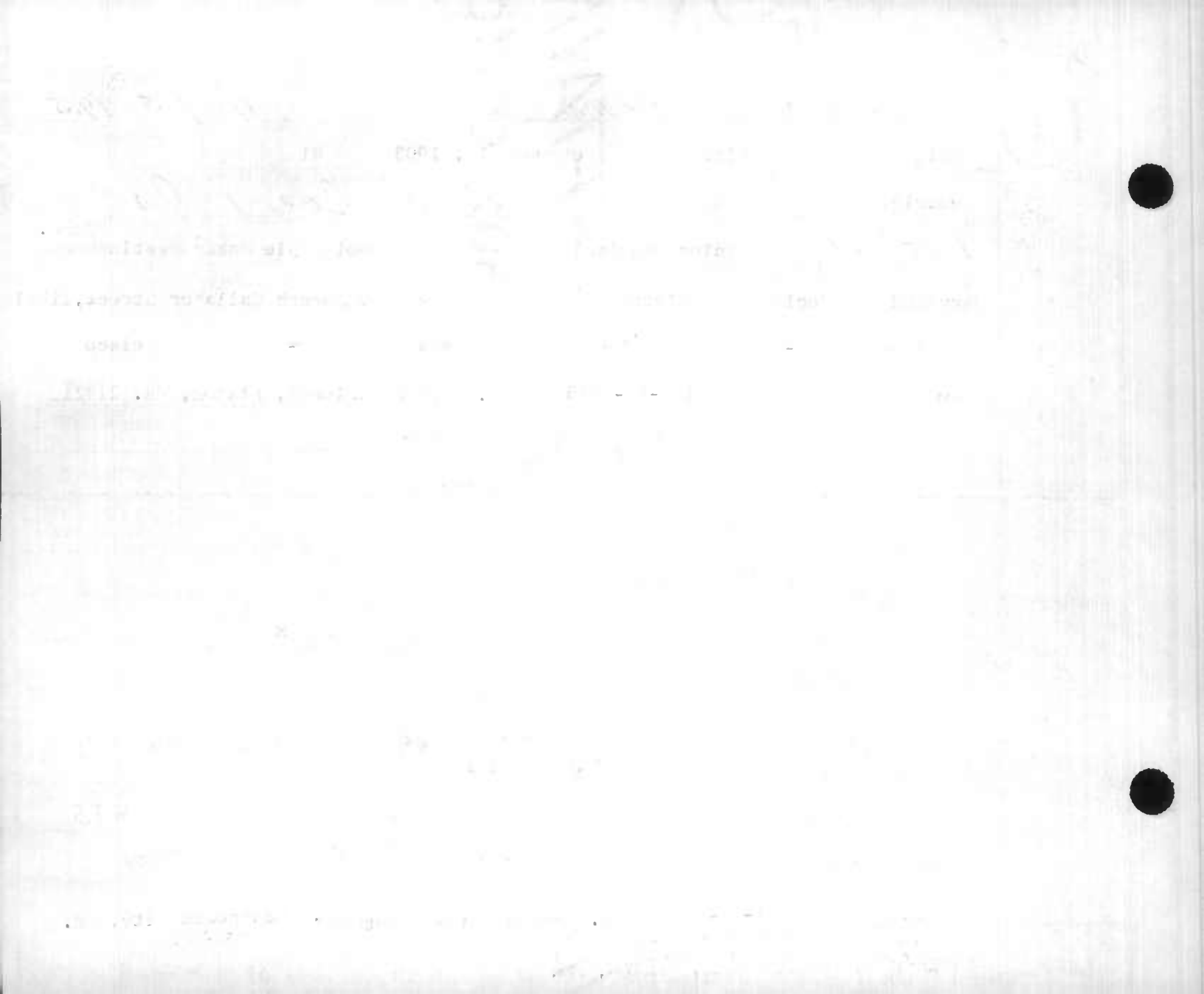
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 84 to 1.13 19 85 , that (we) last saw the deceased alive on 1.13 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sheelmoohan S. Sashden				DEGREE M.D.		22c. DATE SIGNED 1.16.85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHEELMOOHAN S. SASHDEN				22e. ADDRESS 204 Bow St, ELKTON MD 21921			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-16-85		23c. NAME OF CEMETERY OR CREMATORY St. Rose of Lima Cemetery, Chesapeake City, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Ralph E. Hicks ADDRESS HICKS HOME for FUNERALS, ELKTON, MD.				25a. DATE REC'D. BY REGISTRAR JAN 21 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5 0 1 3 3 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hazel M. DeMull				2a. DATE OF DEATH MONTH DAY YEAR 11/18/85			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 27, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Laurelwood nursing center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES BAGENT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBA MCGONIGAL		13e. STREET ADDRESS 135 WILSON STREET		21078	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 80 1798		17. INFORMANT HARRY J. DeMULL		ADDRESS SAME AS #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>County myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerosis - Q5HD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/18</u> 19 <u>85</u> , to <u>1/18</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1/18</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we had I did not view the body after death.)							
22b. SIGNATURE JOSEPH G. LANZI				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-18-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH G. LANZI				22e. ADDRESS 721 BRIDGE ST. ELKTON, MD 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 21 JANUARY 85		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD CO., MD	
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078				25a. DATE REC'D. BY REGISTRAR JAN 21 1985			
				25b. REGISTRAR'S SIGNATURE John Landon-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

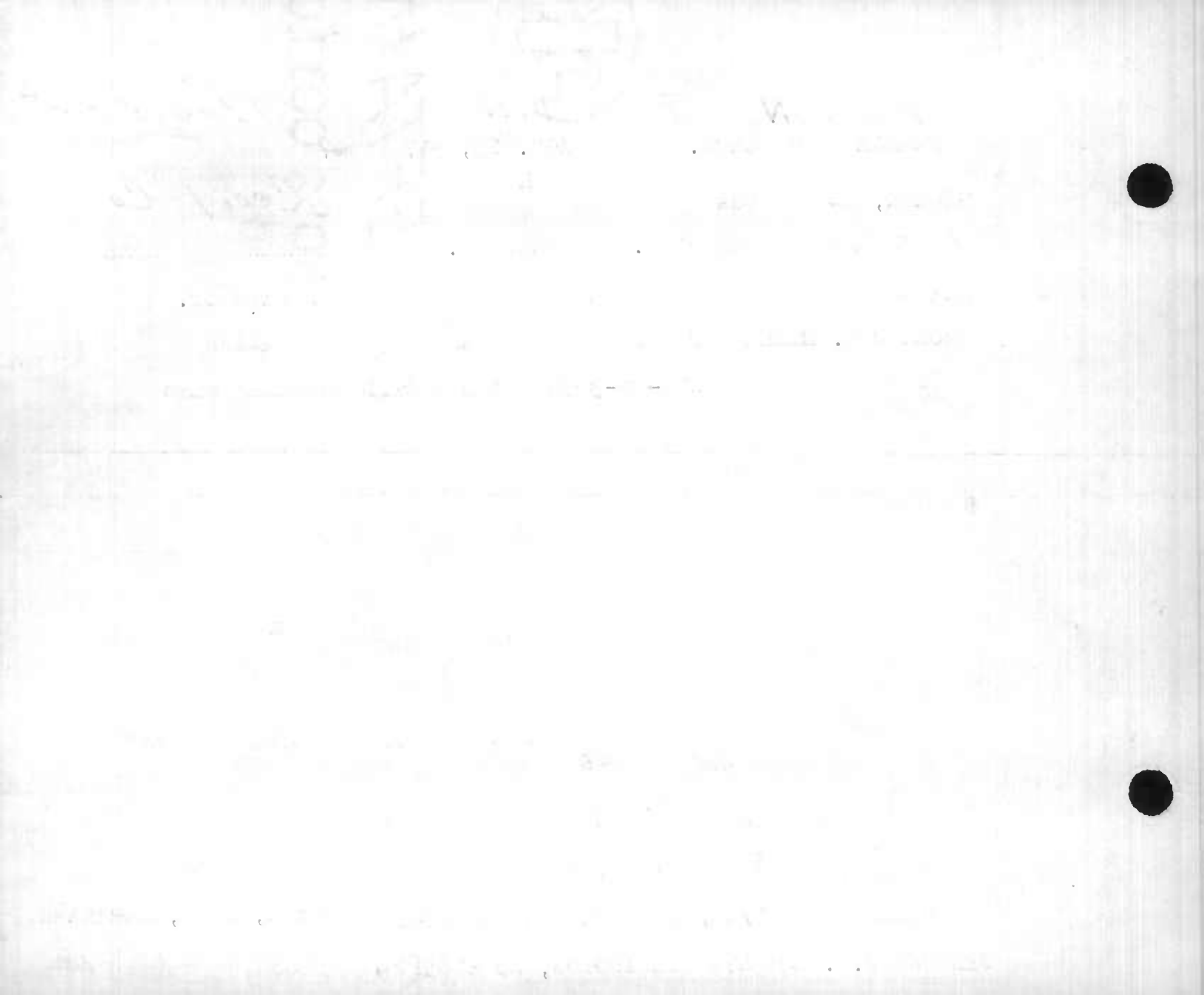
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 3 5

1- FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIAN P. DILL		2a. DATE OF DEATH MONTH DAY YEAR 1/26/85 2b. HOUR 4:25^{PM}	
3 SEX FEMALE	4 RACE CAUC.	5. DATE OF BIRTH NOV. 15, 1917	6 AGE (IN YEARS LAST BIRTHDAY) 67 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GALENA, MD	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.
10. CITY OR TOWN OF DEATH EIKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSP. OF CECIL CO.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY HOME
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY KENT 13c. CITY OR TOWN GALENA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE NORTH MAIN ST. 21635
14 FATHER'S NAME ROLAND R. XXXXX PENNINGTON		15. MOTHER'S MAIDEN NAME MARY QUINN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 218-01-3058	17. INFORMANT ADDRESS WILSON DILL husband same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NO			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/4 , 19 82 , to 1/26 , 19 85 that (I) (we) last saw the deceased alive on 1/25 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Johna Rosenfeld MD		DEGREE MD	22c. DATE SIGNED 1/26/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Johna Rosenfeld MD		22e. ADDRESS Cecil Co. Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/29/85	23c. NAME OF CEMETERY OR CREMATORY GALENA CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE GALENA, KENT, MARYLAND
24 FUNERAL DIRECTOR NAME FELLOWS F.H. BOX 270 MILLINGTON, MD 2165		25a. DATE REC'D. BY REGISTRAR FEB 0 5 1985 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21a shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 3 6

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John K. Dooley			2a. DATE OF DEATH MONTH DAY YEAR January 4, 1985		2b. HOUR 4:45 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 25, 1901	6. AGE (IN YEARS LAST BIRTHDAY) 83	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.		
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital Of Cecil Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Sun Oil	
13a. STATE Md.		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 69 Wood Duck Lane
14. FATHER'S NAME FIRST MIDDLE LAST William J. Dooley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Dempster			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 163-09-6016		17. INFORMANT John Vernon Dooley	
				ADDRESS Elkton Md. 136 W. Thomson Dr.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Auto Myocard Infarction.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) COPD. (Advance).

DUE TO, OR AS A CONSEQUENCE OF

(c) ASCVD.APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>12/8</u> 19 <u>72</u> , to <u>1/4</u> 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>1/3</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Jui Chih Hsu</u> MD		22c. DATE SIGNED <u>1/4/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jui Chih Hsu</u>		22e. ADDRESS <u>223 West Main St. Cecil, Md</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan 7 1985	23c. NAME OF CEMETERY OR CREMATORY Lawn Croft Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Linwood Del. PA.
24. FUNERAL DIRECTOR NAME <u>Geer Funeral Home</u>		25a. DATE REC'D. BY REGISTRAR JAN 1 1985	
ADDRESS <u>ELKTON, MD.</u>		25b. REGISTRAR'S SIGNATURE	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR 100 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR							
Simon		(NMI)		Favicchio Jr.				DATE KNOWN OF DEATH		1		3		85		M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
Male		White		02 23 22		62		MONTHS		DAYS		HOURS		MIN.		1		3		85		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH															
New York		USA		MARRIED		NEVER MARRIED		Cecil															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY																	
Elkton		Union Hospital		Hoffman		Maintenance- Pharmaceuticals																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
New Jersey		Bergen		Lodi		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21 Hamilton Avenue, 07644															
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST													
Simon		-		Favicchio, Sr.		Margaret		-		Unknown													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																	
Yes		WW 2 Army		068-14-1112		Mrs. Margaret Bokara, New Milford, N.J.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1 DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) <u>Coronary Vascular Disease</u>																Many years							
DUE TO, OR AS A CONSEQUENCE OF																							
(c) <u>Heavy Smoking</u>																Many years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																							
<u>Diabetes Mellitus, Emphysema, Heavy Smoking</u>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED												20. AUTOPSY?							
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
				HOUR A.M. MONTH DAY YEAR				died in sleep															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION															
				on a bus				STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED															
Henry Farkas				M.D. MD				1/3/85															
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
Henry Farkas				Union Hosp of Cecil Co.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION											
Burial				1-8-85				St. Marys Cemetery				Saddle Brook, Bergen, New Jersey											
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
HICKS HOME FOR FUNERALS, ELKTON, MD. 21921				JAN 7 1985				John Davidson-Randall															

BP

DMMH - 17
(VR-15 ME (5))
15M7/77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Vanis W FUNK		male		white	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
MONTH DAY YEAR 10 07 07		77 YRS.		Va	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Cecil		Cecil		ELKTON Md	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
UNION Hosp Cecil County		Farmer		Farming	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Cecil		Elkton	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
FIRST MIDDLE LAST William H. Funk		FIRST MIDDLE LAST Bessie - Henry		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio Sclerotic Cardiovascular Dis.</u>	
222-01-6104		Mrs. Linda A. Perovich, Elkton, Md. 21921		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-25</u> 19 <u>85</u> , to <u>1-26</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1-25</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Rolando Nalera, M.D.</u>				1-26-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
ROLANDO NALERA M.D.		105 E. Main Street, Elkton, Md. 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1-29-85		Bouldens Chapel Cemetery, Elkton, Maryland 21921	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Ralph E. Hicks</u>		FEB 1 1985		<u>[Signature]</u>	
HICKS HOME for FUNERALS, ELKTON, MD. 21921					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 3 9

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GIBSON H GOFF JR.			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 23, 1985		2b. HOUR 9:20PM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 8 20 17		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.	
10. CITY OR TOWN OF DEATH PERRY POINT, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY CECIL	13c. CITY OR TOWN PERRYVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GIBSON H GOFF SR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JESSIE JONES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1AUL2	17. INFORMANT ADDRESS RUTH GOFF PERRYVILLE MD		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)
DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JANUARY 3, 19 85, to JANUARY 23, 19 85, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JANUARY 23, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jean T. Pouyes MD		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEAN T. POUYES, M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
		22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL	23b. DATE 1-28-85	23c. NAME OF CEMETERY OR CREMATORY BETHEL	23d. LOCATION CITY OR TOWN COUNTY STATE CHESAPEAKE CITY MD
24. FUNERAL DIRECTOR (TYPE OR PRINT) FOARD FUNERAL HOME, CHESAPEAKE CITY, MD		25. DATE REC'D BY REGISTRAR JAN 29 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 4 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD W. HAMILTON			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 19, 1985			2b. HOUR 8:15A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH PERRY POINT, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1987 Old Neck Road 21921	
14. FATHER'S NAME FIRST MIDDLE LAST David A. Hamilton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia McGovern					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 163-07-2016		17. INFORMANT ADDRESS Rose Hamilton 1987 Old Neck Road Elkton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>POSSIBLE PNEUMONIA, CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (he/she) attended the deceased from <u>DECEMBER 27</u> , 19 <u>85</u> , to <u>JANUARY 19</u> , 19 <u>85</u> , that (he/she) last saw the deceased alive on <u>JANUARY 19</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (he/she) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dilip S. Kittus</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DILIP S. KITTUS, M.D.				22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 23, 1985		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chester Pennsylvania			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Md.				25. DATE REC'D. BY REGISTRAR JAN 22 1985		25. REGISTRAR'S SIGNATURE			
BATTENMAN FUNERAL HOME, BROOKHAVEN, PA.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a copy retained.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

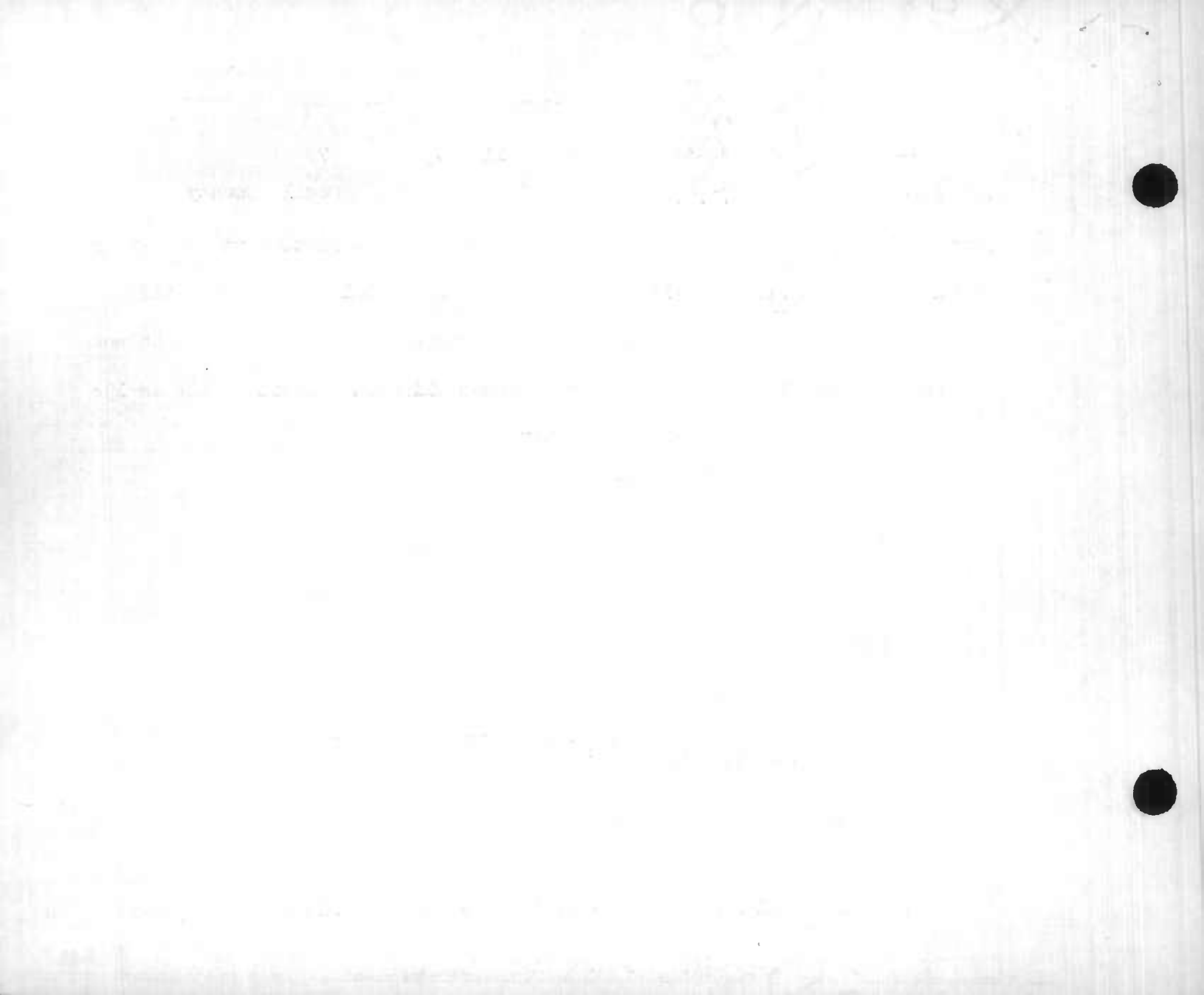
8 5 0 1 8 4 1

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS G HEBERT			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 26 1985		2b. HOUR 10:25AM
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 11 05		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Louisiana	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Perryville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER PERRY POINT MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent		12b. KIND OF BUSINESS OR INDUSTRY Paper
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY A.A.	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST O Hebert			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 327 05 2097		17. INFORMANT ADDRESS Susan Elizabeth Hebert Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 17, 1982 , to JANUARY 26, 1985 , that (I) (we) lost saw the deceased alive on JANUARY 26, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Sean P. Puyes MD		DEGREE		22c. DATE SIGNED 1/26/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/29/85	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Howard Md	
24. FUNERAL DIRECTOR NAME GEORGE GONCE FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR JAN 30 1985		
ADDRESS BROOKLYN PARK MD			25b. REGISTRAR'S SIGNATURE John Davidson Randall		

BP _____



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

Item 6001 item 166

2/13/85 rja
1- STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 4 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARLENE A JACKSON			2a. DATE OF DEATH MONTH DAY YEAR 1/20/85			2b. HOUR 13:50 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 24 1934		6. AGE (IN YEARS LAST BIRTHDAY) 50 yrs.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.			
10. CITY OR TOWN OF DEATH EIKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 816 Jackson Station Rd. 21903									
14. FATHER'S NAME FIRST MIDDLE LAST Clarence J. Stevens			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty M. Parker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 576-44-3898		17. INFORMANT ADDRESS Lewis R. Jackson, Jr. Perryville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST ANOXIC ENCEPHALOPATHY 1 week. DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) -----									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) -----									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1-20- 19 85 , to 1-20- 19 85 , that (I) (we) lost saw the deceased alive on 1-20- 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ehsanur Rahman			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EHSANUR RAHMAN			22e. ADDRESS 2102 DRUMMOND PLAZA NEWARK, DE 19711						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 23, 1985		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit Cecil Maryland		
24. FUNERAL DIRECTOR Lee A. Patterson & Son			25a. DATE REC'D. BY REGISTRAR JAN 28 1985			25b. REGISTRAR'S SIGNATURE John T. ...			

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to autopsify.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

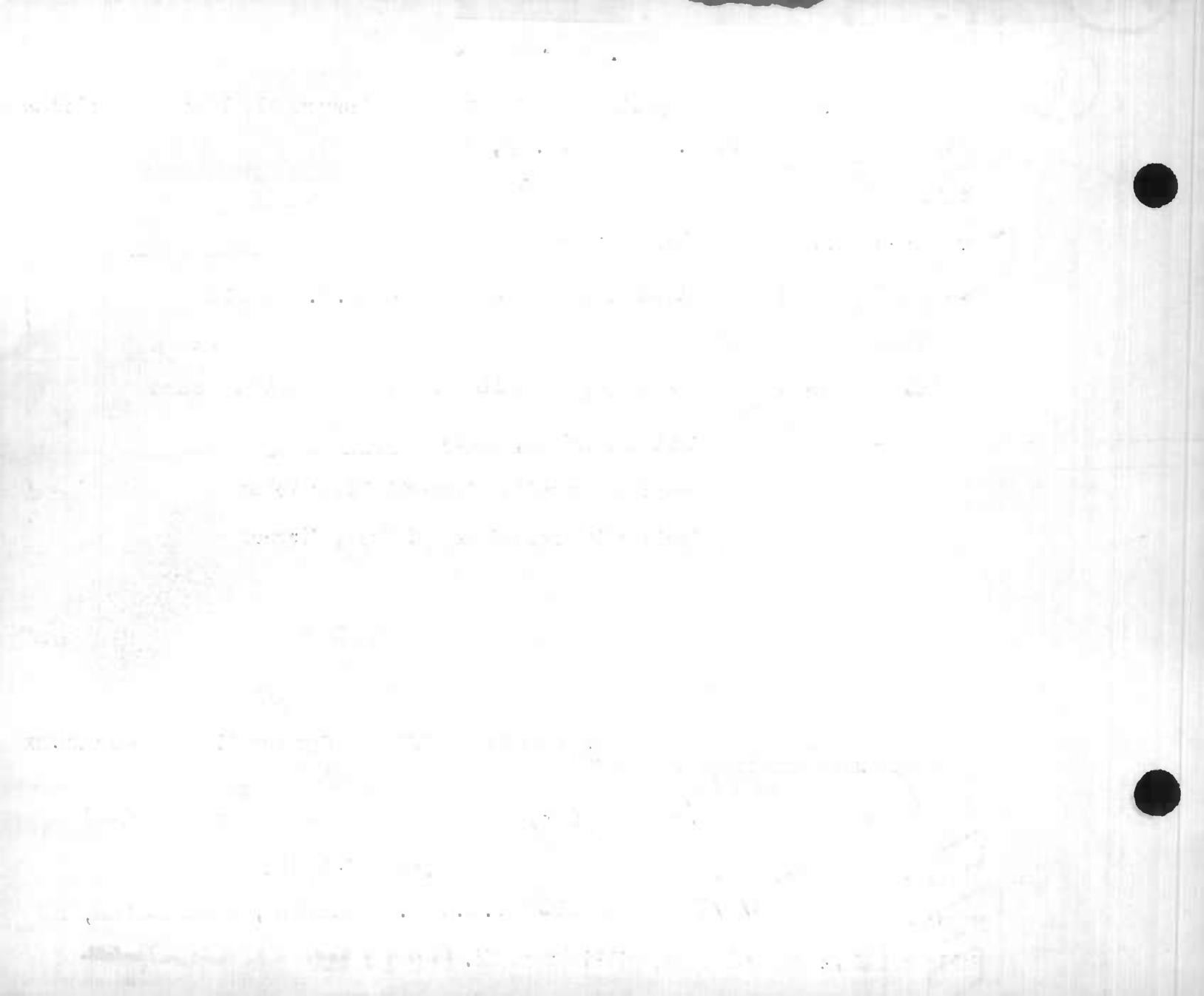
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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES Rawlings JONES			2a. DATE OF DEATH MONTH DAY YEAR January 31, 1985			2b. HOUR 11:35pm			
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH Aug. 3, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN) MILLINGTON		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.			
12. CITY OR TOWN OF DEATH Perry Point, Md.		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION VA Medical Center				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MILL WORKER		15. KIND OF BUSINESS OR INDUSTRY MILL	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3a. STATE MARYLAND 3b. COUNTY KENT 3c. CITY OR TOWN MILLINGTON			17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS / ZIP CODE P.O. BOX 116 21651				
19. FATHER'S NAME CORBET JONES			20. MOTHER'S MAIDEN NAME JENNY BAKER						
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES WW I			22. SOCIAL SECURITY NO. 147-12-3553		23. INFORMANT ADDRESS EMILY ANNE JONES wife same				
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastroenteritis, acute DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia, bilateral lower lobes DUE TO, OR AS A CONSEQUENCE OF (c) Pericardial adhesions, diffuse, fibrous								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
25. DATE OF OPERATION			26. CONDITION FOR WHICH OPERATION WAS PERFORMED			27. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
32. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE				
35. I certify that (This hospital) attended the deceased from January 28, 1985, to January 31, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
36. SIGNATURE J. R. GARCIA, M.D.					37. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			38. DATE SIGNED 2-1-85	
39. PHYSICIAN'S NAME (TYPE OR PRINT) J. R. GARCIA, M.D.					40. ADDRESS VAMC, Perry Point, Md.				
41. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			42. DATE 2/4/85		43. NAME OF CEMETERY OR CREMATORY HURLOCK V.A.CEM.		44. LOCATION HURLOCK, DORCHESTER, MD		
45. FUNERAL DIRECTOR NAME Fellows & Sons Funeral Home, Millington, Md.					46. DATE REC'D. BY REGISTRAR FEB 11 1985		47. REGISTRAR'S SIGNATURE John Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. DECEASED NAME (TYPE OR PRINT) Robert D. Knauss, Sr.					2a. DATE OF DEATH MONTH January DAY 5 YEAR 1985					2b. HOUR 12:40 PM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH August DAY 7 YEAR 1915			6 AGE (IN YEARS LAST BIRTHDAY) 69 yrs. YRS.			7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.						
10. CITY OR TOWN OF DEATH Port Deposit		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 85 Burlin Road					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineering Svc.			12b. KIND OF BUSINESS OR INDUSTRY V.A.M.C., Perry			
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 85 Burlin Road			13f. ADDRESS Point, Md. 21904		
14. FATHER'S NAME FIRST Charles MIDDLE C. LAST Knauss				15. MOTHER'S MAIDEN NAME FIRST Blanche MIDDLE LAST Brown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-1135		17. INFORMANT ADDRESS Ellen K. Bradley 111 Burlin Road Port Deposit, Md. 21904							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Terminal 2A of Prostate DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Eddie S. Saw, M.D.						DEGREE			22c. DATE SIGNED 1/7/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
Eddie S. Saw, M.D.						135 W. Main St., Elkton, Md. 21087							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Jan. 8, 1985		23c. NAME OF CEMETERY OR CREMATORY Cratin & Ferris			23d. LOCATION CITY OR TOWN COUNTY STATE West Chester Chester Penn.					
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.						25a. DATE REC'D. BY REGISTRAR JAN 14 1985							
25b. REGISTRAR'S SIGNATURE													

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Re: [illegible]
[illegible]

7/1/11

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 5 0 1 8 4 5

 1- FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ralph L. Lanphar			2a. DATE OF DEATH MONTH DAY YEAR 1-28-85		2b. HOUR 3:00p_M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YR. 12 28 02		
6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN. MD.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mi		7b. CITIZEN OF WHAT COUNTRY? US A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County		10. CITY OR TOWN OF DEATH Elkton				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Manager		12b. KIND OF BUSINESS OR INDUSTRY Hotel		
13a. STATE MD		13b. COUNTY Cecil		13c. CITY OR TOWN North East		
14. FATHER'S NAME FIRST MIDDLE LAST Daniel B. Lanphar		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Raser				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO. 386-03-4730		17. INFORMANT Ralph R. Lanphar		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 1 hr.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension; Diabetes mellitus; cerebral vascular disease						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1/28 19 82 to 1/28 19 85 , that (I) (we) last saw the deceased alive on 1/28 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Edgar E. Folk III		DEGREE MD.		22c. DATE SIGNED 1/28/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar E. Folk III, MD.		22e. ADDRESS Union Hospital, Elkton, Md. 21921				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-31-85		23c. NAME OF CEMETERY OR CREMATORY White Chapel Mem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Troy Oakland Mich.		24. FUNERAL DIRECTOR NAME Robert F. [unclear]				
25a. DATE REC'D. BY REGISTRAR JAN 31 1985		25b. REGISTRAR'S SIGNATURE [Signature]				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CC:

28-85-1

TABLE 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 4 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elizabeth C. Maloney			2a. DATE OF DEATH MONTH DAY YEAR HOUR January 3, 1985 3:09 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 4, 1904	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Principal	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Cecil 13c CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1080 Frenchtown Road 21921	
14. FATHER'S NAME FIRST MIDDLE LAST James Maloney	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Gracey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-18-7110	17. INFORMANT ADDRESS Ella Maloney 1080 Frenchtown Rd. Elkton		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Heart Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>				
MEDICAL CERTIFICATION				
19a. DATE OF OPERATION 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I, this hospital) attended the deceased from <u>APR 25</u> 19 <u>85</u> , to <u>JAN</u> 19 <u>85</u> , that (I, we) last saw the deceased alive on <u>APR 25</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we did not view the body after death).				
22b. SIGNATURE <u>Dr. Joseph G. Lanzi M.D.</u>	DEGREE M.D.	22c. DATE SIGNED 1-3-85		22d. ADDRESS 721 Bridge Street Elkton, Md.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 5, 1985	23c. NAME OF CEMETERY OR CREMATORY Immac. Conception	23d. LOCATION CITY OR TOWN COUNTY STATE Cherry Hill Cecil Md.	23e. DATE REC'D. BY REGISTRAR JAN 7 1985
24. FUNERAL DIRECTOR NAME <u>Edward A. ...</u> ADDRESS <u>Funeral Home Elkton, Maryland</u>				

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B/E/A

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8501847

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PEARL I MORRIS			2a. DATE OF DEATH MONTH DAY YEAR 1/27/85		2b. HOUR MIN. 4:45A
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 3 1912	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. UNDER 1 YEAR MONTHS DAYS 72
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.		
10. CITY OR TOWN OF DEATH ERITON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPT		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DYE WORKS		12b. KIND OF BUSINESS OR INDUSTRY —
13a. STATE MD			13b. COUNTY CECIL	13c. CITY OR TOWN CRYSTOL BEACH	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM B MORRIS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA V. LONG		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 169-180430		17. INFORMANT ADDRESS JENNY RICCI 311 E 20th ST CHESTER	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

MYOCARDIAL INFARCTIONAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**2 days**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **ARTERIOSCLEROTIC HEART DISEASE****many yrs**

DUE TO, OR AS A CONSEQUENCE OF

(c) **HYPERTENSION****many yrs**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

DIABETES, OBESITY

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/26 19 85 to 1/27/85 19 85 that (I) (we) last saw the deceased on 1/26 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated view the body after death.			
22b. SIGNATURE Joann Rosenfeld	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/26/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOANN ROSENFELD MD		22e. ADDRESS Box 415, Cecilton MD 21523	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 1-30-85	23c. NAME OF CEMETERY OR CREMATORY Cremation Specialist Media Del.	23d. LOCATION CITY OR TOWN COUNTY STATE ERITON, MD
24. FUNERAL DIRECTOR Joe Funeral Home		25a. DATE REC'D. BY REGISTRAR FEB 05 1985	
25b. REGISTRAR'S SIGNATURE Lia Tardien-Rivera			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or signed as due to injury or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified before.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2b. DATE OF DEATH MONTH DAY YEAR	
James William Murphy					Jan. 21, 1985	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR P.M.	
Male	White	Sept. 5, 1910	74 YRS.		2:35 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Elkton, Md.	USA		Cecil MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Elkton	Union Hospital			Ret. Penna.R.R. Railroad		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN	13c. STREET ADDRESS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.		Cecil	55 Blossom Lane		21921	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
William A. Murphy		Anna Mae Moore		no		
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
219-05-9806		Mary J. Murphy 55 Blossom Lane, Elkton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>						
DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
(b) <u>EVA, pneumonia</u>						
DUE TO, OR AS A CONSEQUENCE OF						
(c) <u>Adverse COPD, Emphysema</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (a) (this hospital) attended the deceased from <u>11/2</u> 19 <u>72</u> , to <u>1/21</u> 19 <u>85</u> , that (I/we) last saw the deceased alive on <u>1/21</u> 19 <u>85</u> , and that it (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.						
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
<u>Jui-wil Hsu</u>		MD				1/22/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
<u>Jui-chih Hsu</u>		223 West main st, Elkton Md 21921				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1-24-85	Elkton, Md. Cemetery		Elkton Cecil Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		
<u>[Signature]</u>				25b. REGISTRAR'S SIGNATURE		
				<u>[Signature]</u>		

BP

20% COTTON FIBRE

WHEAT



Handwritten signature or mark at the bottom of the page.

Extremely faint and mostly illegible text, possibly bleed-through from the reverse side of the paper. Some fragments are visible, such as "WHEAT", "COTTON", and "FIBRE".

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 4 9

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>JULIAN B. MURRAY</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>1/14/85</i>		2b. HOUR <i>1000^A</i>	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 28, 1922</i>	
6. AGE (IN YEARS LAST BIRTHDAY) 62		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i> MD	
12. CITY OR TOWN OF DEATH <i>ELKTON</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Group Leader	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware		13b. CITY OR TOWN New Castle		13c. STREET ADDRESS / ZIP CODE 18 Augusta Dr. 19711	
14. FATHER'S NAME FIRST MIDDLE LAST George Murray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia McMullen Murray		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II	
17. SOCIAL SECURITY NO. 221-14-6433		18. INFORMANT Mrs. Betty B. Murray		19. ADDRESS 18 Augusta Dr. Newark, DE 19711	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *CARDIAC ARRHYTHMIA + CARDIO MYOPATHY*

DUE TO, OR AS A CONSEQUENCE OF

(b) *DELIRIUM TREMORS, ALCOHOL ADDICTION*

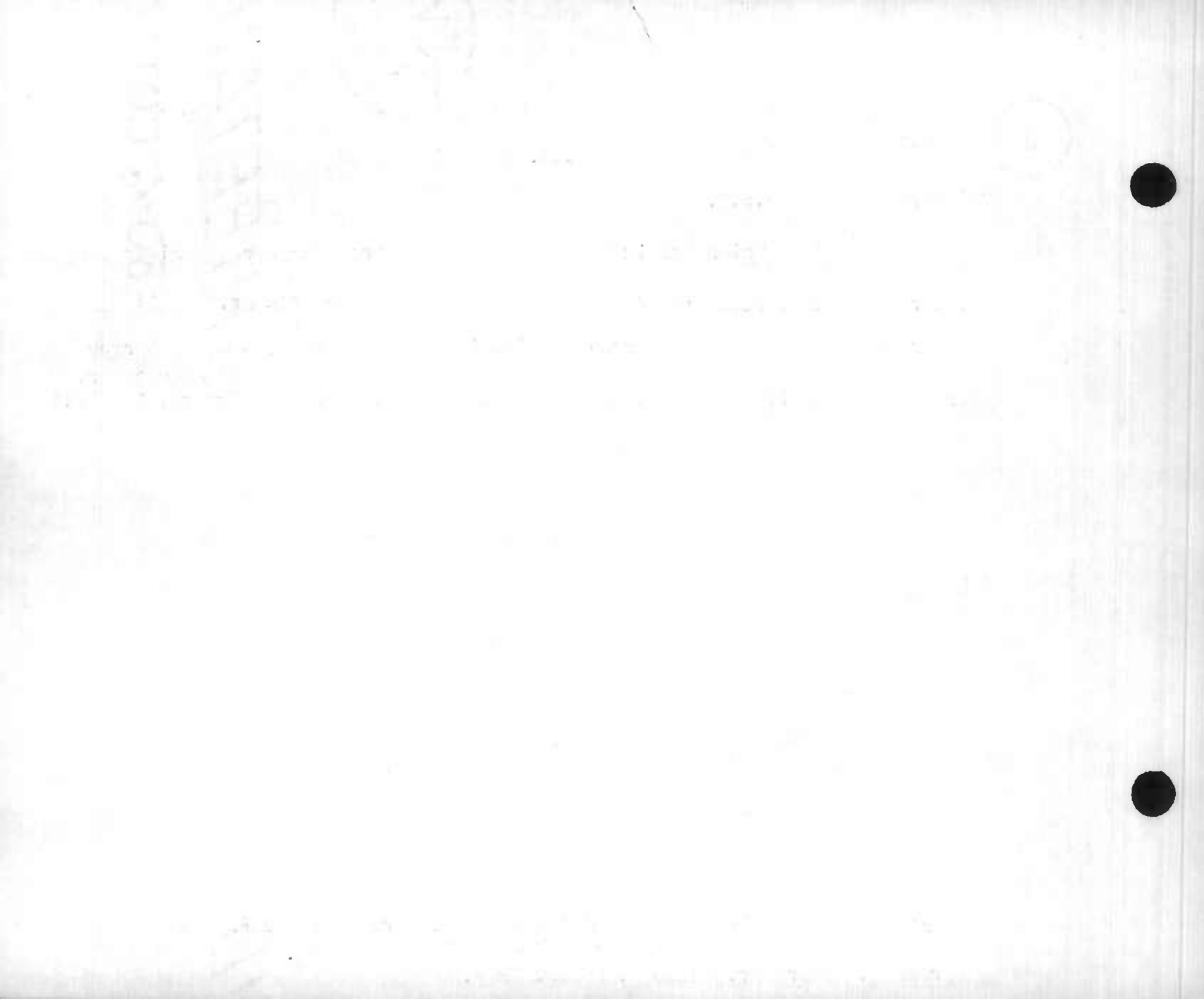
DUE TO, OR AS A CONSEQUENCE OF

(c) *ASPIRATION PNEUMONIA + GASTRIC BLEED*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/8</i> 19 <i>85</i> , to <i>1/14</i> 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>1/13</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Gary Beste</i>		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GARY Beste MD</i>		22f. ADDRESS <i>Newark Del</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 17, 1985		23c. NAME OF CEMETERY OR CREMATORY Gracelawn Meml Park		23d. LOCATION CITY OR TOWN COUNTY STATE New Castle New Castle, DE	
24. FUNERAL DIRECTOR NAME Frank C. Mayer, Jr.		24. FUNERAL DIRECTOR ADDRESS 1000 N. DuPont Pkwy.		25. REGISTRAR'S SIGNATURE <i>John C. Mayer</i>			



TO HOSPITAL OR ATTENDING PHYSICIANS: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

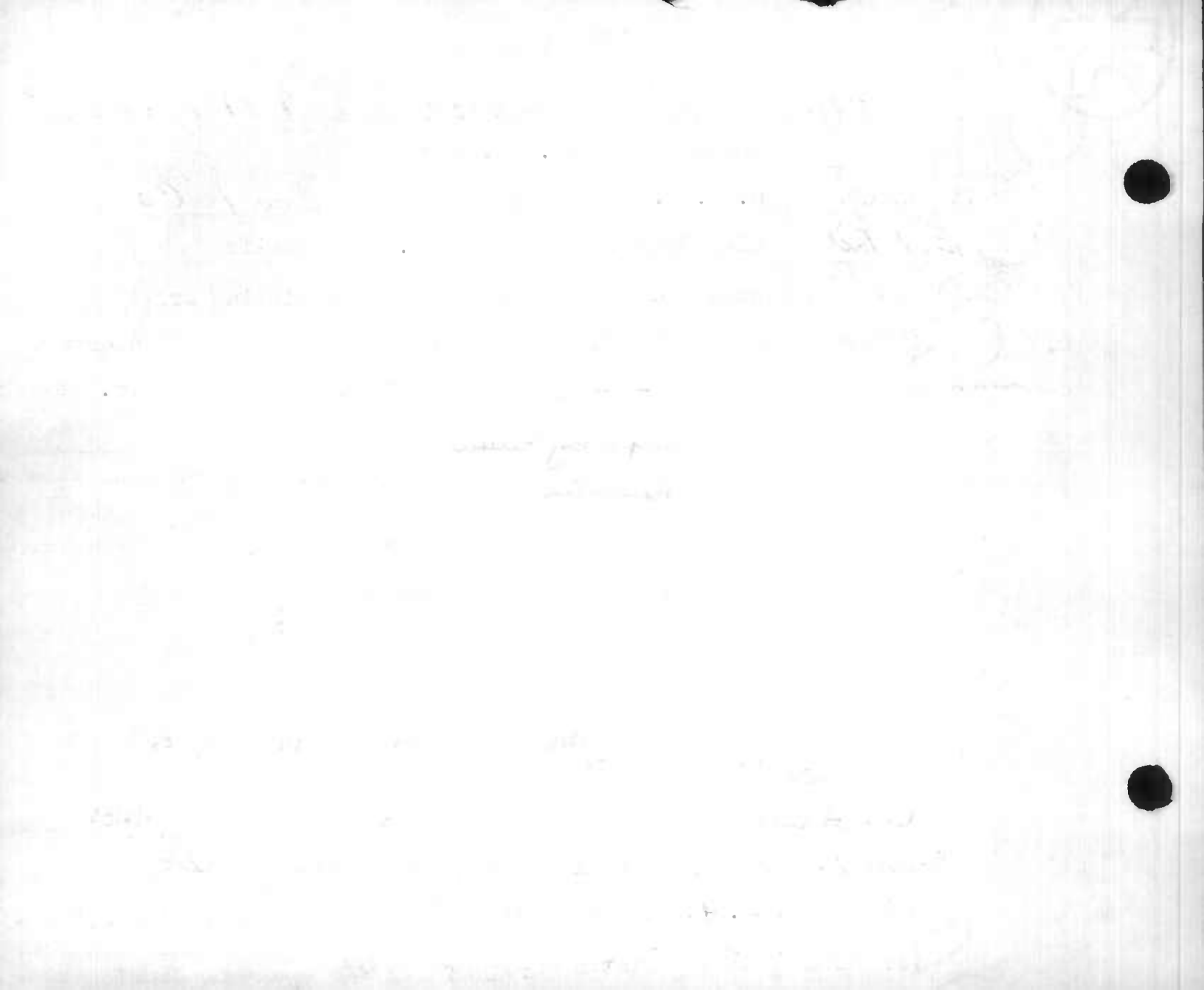
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 5 0

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IYA M. PAINTER		2a. DATE OF DEATH MONTH DAY YEAR 1/11/85 2b. HOUR 6:50 P	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 31, 1902	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 81	
10. CITY OR TOWN OF DEATH EIKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital Of Cecil Co.	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13b. COUNTY NewCastle		13c. CITY OR TOWN Newark	
14. FATHER'S NAME FIRST MIDDLE LAST William Simmons		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Puffenbargar	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 155-44-9195	
17. INFORMANT ADDRESS William Simmons #6 Kipling Dr. Newark			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no			
19a. DATE OF OPERATION			
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/30 19 84 to 1/11 19 85 , that (I) (we) last saw the deceased alive on 1/11 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Kenneth Lewis MD		22c. DATE SIGNED 1/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth Lewis MD		22e. ADDRESS Middle town Del	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 4, 1985	
23c. NAME OF CEMETERY OR CREMATORY Eglinton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clarksboro Gloucester Nj	
24. FUNERAL DIRECTOR NAME Free Funeral Home		25a. DATE REC'D. BY REGISTRAR JAN 7 1985	
25b. REGISTRAR'S SIGNATURE Julia K. [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 0185

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST JOSEPH		MIDDLE A.		LAST PATTERSON		2a. DATE OF DEATH MONTH January 28, 1985		2b. HOUR 10:25A			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH APRIL 3, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL COUNTY MD							
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) SELF EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY PLUMBER					
13a. STATE MD				13b. CITY OR TOWN HARFORD		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 108 MARKET STREET 21078					
14. FATHER'S NAME FIRST JOHN				MIDDLE FRANCIS		LAST PATTERSON		15. MOTHER'S MAIDEN NAME FIRST SADIE				MIDDLE RILEY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW II		17. INFORMANT MRS. AUDREY PATTERSON		ADDRESS SAME AS #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cachexia and cardio pulmonary failure DUE TO, OR AS A CONSEQUENCE OF (c) prostatic Extensive metastatic lesions due to cancer of										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from November 20, 1984, to January 28, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE JULIAN OCEJO, M. D.								DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-28-85			
22d. ADDRESS VA Medical Center, Perry Point, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 31 JANUARY 85		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY		23d. LOCATION CITY OR TOWN HARFORD CO., MD.							
24. FUNERAL DIRECTOR NAME Mitchell Funeral Home, Havre de Grace, Md.						ADDRESS 21078		25a. DATE REC'D. BY REGISTRAR JAN 29 1985		25b. REGISTRAR'S SIGNATURE Davidson-Randall			

...and the ...

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 5 2

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Norm M. Reburn</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>JAN 30 1985</i>		2b. HOUR <i>10 P.M.</i>	
3. SEX <i>F</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>MARCH 18 1893</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>91</i> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>CECIL MD.</i>
10. CITY OR TOWN OF DEATH <i>CALVERT MD.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>CALVERT MANOR NURS Home, INC.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House wife</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Pa.</i>		13b. COUNTY <i>OXFORD</i>		13c. CITY OR TOWN <i>OXFORD</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>WILMER McINTyre</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNIE Huss</i>		13e. STREET ADDRESS / ZIP CODE <i>402 LARGE Rd. 19363</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>189-26-491</i>		17. INFORMANT ADDRESS <i>William W. Shepherd 902 Shady Side Oxford, Pa. Rd.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral ischemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASVD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>years</i> <i>years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>CVA; Hypertension; Renal failure</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-85</i> , to <i>1-30-85</i> , that (I) (we) last saw the deceased alive on <i>1-30-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED <i>1-31-85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G.T. HOLCO MB</i>		22e. ADDRESS <i>OXFORD, PA. 19363</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>2/4/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>OXFORD</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>OXFORD CHESTER PA</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>Richard L. Grodie Rising Sun, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 0 5 1985</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMM-16 20M
(VRA 15, 4) 7/78STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 5 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Nolie Charsha Simmers</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>January 19 1985</i>		2b. HOUR <i>3:30 p.m.</i>								
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 9 1900</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>84 yrs.</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil County</i> MD.							
10 CITY OR TOWN OF DEATH <i>Perryville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Residence - 620 Charles Street</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY -----					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Perryville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>620 Charles Street 21903</i>					
14 FATHER'S NAME FIRST MIDDLE LAST <i>William W. Charsha, Sr.</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Reburn</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>Unknown</i>		17 INFORMANT <i>Joseph W. Simmers</i>				ADDRESS <i>Perryville, Md. 21903</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ASCOPD</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Old CVA</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5:20 P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>5/20</i> 19 <i>84</i> to <i>5/19</i> 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>5/19</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>J.J. Lee</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			THE DATE SIGNED <i>5/28/85</i>				
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J.J. Lee, M.D.</i>			22d. ADDRESS <i>319 South Union Ave., Havre de Grace, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Jan. 22, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hopewell Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Port Deposit Cecil Maryland</i>					
24. FUNERAL DIRECTOR <i>Lee H. Patterson & Son, Perryville, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>5/28/85</i>						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
CLEMENS				ARTHUR		TITTEL, SR		January 14, 1985								3:20pm			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR				IF UNDER 24 HRS			
Male		White		June 11, 1902				82				MONTHS				DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
Germany		U.S.A.								Cecil									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Perry Point, Md.		VA Medical Center								Army				U.S. Gov.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE											
Maryland		Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		503 Charles St. Ave. 21204											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST				FIRST MIDDLE LAST															
Unknown				Unknown															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS															
Yes		WW II		230-38-7585		Clemens A. Tittel, Jr. - Same as #13e													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Cardiac arrest																			
DUE TO, OR AS A CONSEQUENCE OF																			
(b) Cardiorespiratory failure																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c) Chronic obstructive pulmonary disease, advanced																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY				21f. LOCATION													
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE													
22a. I certify that X (this hospital) attended the deceased from January 24, 1983, to January 14, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE																DEGREE		22c. DATE SIGNED	
Julian Ocejjo M.D.																ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		1-14-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS													
JULIAN OCEJO, M.D.						VA Medical Center, Perry Point, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION											
Burial		1-17-85		Dulaney Valley				Towson, Baltimore, Maryland											
24. FUNERAL DIRECTOR																			
NAME 1050 York Rd. Towson, Md. 21204																			
RUCK-TOWSON FUNERAL HOME INC TOWSON MD.																			
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE																			
JAN 16 1985 Julia Davidson-Randall																			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 8 5 5

REG. NO.

1. NAME (PRINT) FIRST MIDDLE LAST CLIFFORD M. VEASEY			2a. DATE OF DEATH MONTH DAY YEAR January 21, 1985		2b. HOUR 1:20pm
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar. 15, 1922	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cecil Co., Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self-employed	12b. KIND OF BUSINESS OR INDUSTRY Plumber	
13a. STATE Md.			13b. COUNTY Cecil	13c. CITY OR TOWN North East	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John H. Veasey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Rea		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW 2	17. INFORMANT ADDRESS Elkton, Md. Virginia M. Hessey 77 Hollingsworth Manor		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure and renal failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from December 28 , 19 84 , to January 21 , 19 85 XXXXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Julian Ocejjo M.D.		DEGREE M.D.		22c. DATE SIGNED 1-21-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN OCEJO, M.D.		22e. ADDRESS VAMC, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-14-85	23c. NAME OF CEMETERY OR CREMATORY North East Meth Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.		
24. FUNERAL DIRECTOR NAME Gee Funeral Home, Elkton, Md.		DATE RECEIVED BY REGISTRAR JAN 24 1985 REGISTRAR'S SIGNATURE John Davidson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

TO HOSPITAL OR AFTER
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TO FUNERAL DIRECTOR
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with the State Dept. of H
IMPORTANT: If item 21 is

24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
22b. SIGNATURE		DEGREE					
I hereby certify that (I) (this hospital) attended the deceased from _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the cause saw the deceased alive on _____, 19____, above, (I) (we) (did) (did not) view the body after death.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>					
22c. DATE SIGNED							

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

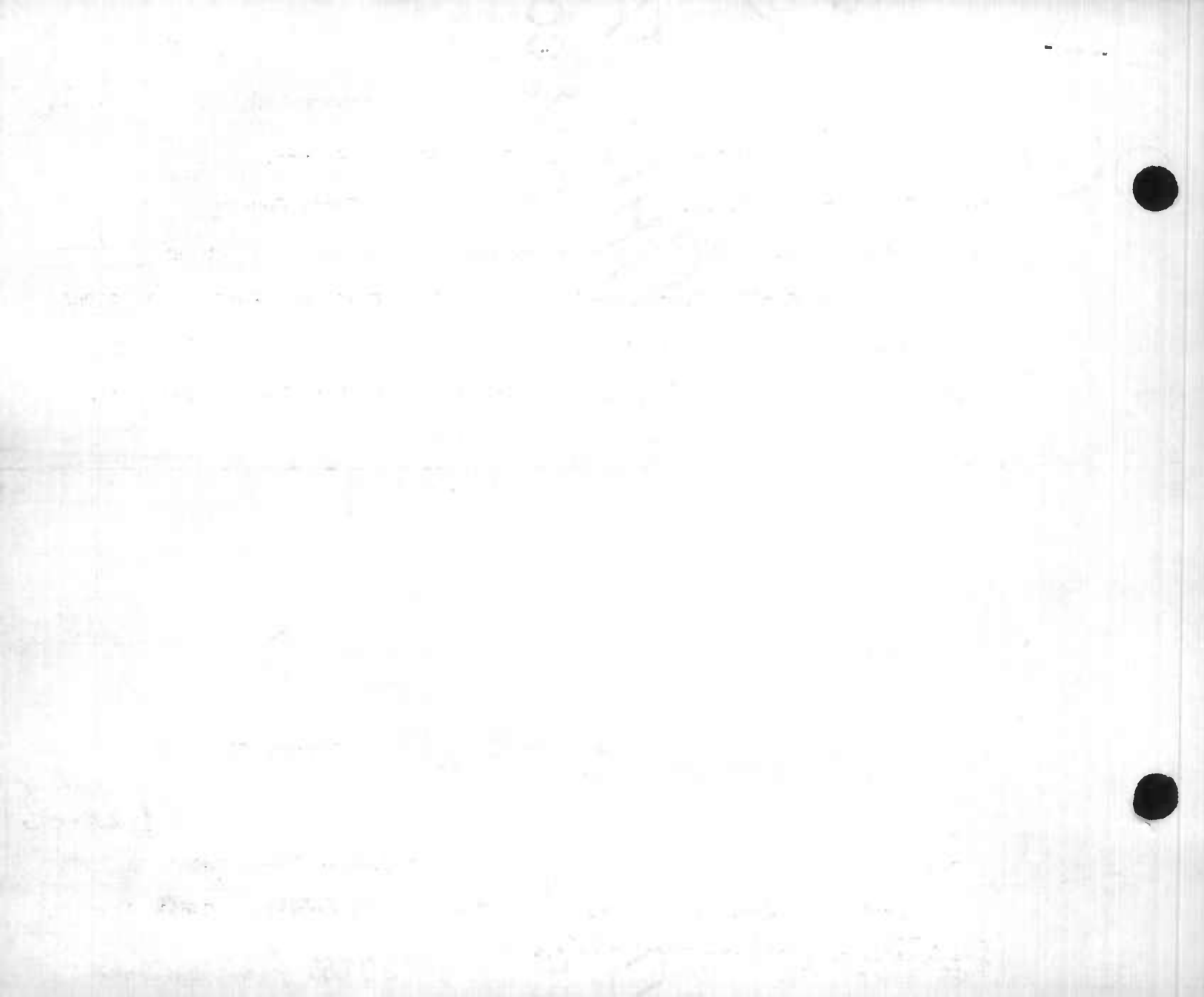
8 5 0 1 8 5 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wallace Willien			2a. DATE OF DEATH MONTH DAY YEAR January 23, 1985		2b. HOUR 5:35A M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 3 1925		6. AGE (IN YEARS LAST BIRTHDAY) 59 yrs. YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center, Perry Point, MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Worker	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Craigtown Road 21904							
14. FATHER'S NAME FIRST MIDDLE LAST William A. Willien				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna --- Perkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1943-1945		17. INFORMANT ADDRESS Richard W. Willien, Port Deposit, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from January 10, 1985, to January 23, 1985, that (I) (we) last saw the deceased alive on January 23, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Prem Lal				DEGREE M.D.		22c. DATE SIGNED 1-23-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Prem Lal				22e. ADDRESS VA Medical Center, Perry Point, MD 21902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 25, 1985		23c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery		23d. LOCATION Perryville Cecil Maryland	
24. FUNERAL DIRECTOR Patterson and Son, Perryville, MD				25a. DATE REC'D. BY REGISTRAR JAN 29 1985			
				25b. REGISTRAR'S SIGNATURE John K. ...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 5 0 1 8 5 7			
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Margaret B. Wright				2a. DATE OF DEATH MONTH DAY YEAR January 25, 1985		2b. HOUR 9:45 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 2, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. IF UNDER 1 YEAR MONTHS DAYS IF 1 YEAR OR OVER YEARS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jewissville, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. STATE Md.				13b. COUNTY Cecil		13c. CITY OR TOWN Elkton	
14. FATHER'S NAME FIRST MIDDLE LAST James Anderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Cox			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 218-38-4434		17. INFORMANT ADDRESS Palmyra, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction				18. CAUSE OF DEATH (continued) DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (c) over 10 yrs.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from Nov. 15, 1972 to Jan. 25, 1985 , that (I) (we) last saw the deceased alive on Jan. 23, 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i> M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/26/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Ralph Andrews, M.D.				22e. ADDRESS 233 E. Main St., Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 1-30-85		23c. NAME OF CEMETERY OR CREMATORY Kemblesville Cem.		23d. LOCATION Chester Co.	
24. FUNERAL DIRECTOR GEE Funeral Home				25. REGISTERAR'S SIGNATURE <i>[Signature]</i>			

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CHIFFON



SEE FIRST PAGE
FOR
BIRTON LTD